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# What You Don't Know Will Hurt You: Physicians' Duty to Warn Patients about Newly Discovered Dangers in Previously Initiated Treatment

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# NOTES

## WHAT YOU DON'T KNOW WILL HURT YOU: PHYSICIANS' DUTY TO WARN PATIENTS ABOUT NEWLY DISCOVERED DANGERS IN PREVIOUSLY INITIATED TREATMENT

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### INTRODUCTION

CERTAIN DOCTRINES IN TORT THEORY have been developed in response to the special relationship between a physician and his patient. Many of these theories have come to be known as "duties," the breach of which will subject the doctor to liability for negligence—medical malpractice. These affirmative duties include (1) the duty to exercise the special care and skill possessed by physicians;<sup>1</sup> (2) the duty to gather operative facts upon which to base a diagnosis;<sup>2</sup> and (3) the du-

<sup>1</sup> *Brown v. United States*, 419 F.2d 337 (8th Cir. 1970); *Ayers v. Parry*, 192 F.2d 181 (3d Cir.), cert. denied, 343 U.S. 980 (1951), reh'g denied, 344 U.S. 849 (1952), 344 U.S. 916, and 345 U.S. 961 (1953); *Newman v. Zinn*, 164 F.2d 558 (3d Cir. 1947).

<sup>2</sup> *Clark v. United States*, 402 F.2d 950 (4th Cir. 1968); *Alden v. Providence Hosp.*, 382 F.2d 163 (D.C. Cir. 1967); *Hicks v. United States*, 368 F.2d 626 (4th

ty to obtain informed consent prior to treatment.<sup>3</sup>

In recent years medical negligence liability has expanded greatly. Increasingly, the courts have made it easier for plaintiff patients to demonstrate a cause of action. By using the doctrines of *res ipsa loquitur*,<sup>4</sup> joint venture liability<sup>5</sup> and enterprise liability,<sup>6</sup> the heavy burden of proof has been lessened dramatically and in some instances completely removed. The trend of expanding medical negligence liability was bolstered in *Tresemmer v. Barke*,<sup>7</sup> a 1978 California decision. *Tresemmer* involved a patient who based her theory of recovery on the proposition that the defendant doctor had a duty to warn her of the dangerous effects of her I.U.D. when, subsequent to its insertion, he obtained knowledge of its hazards.<sup>8</sup> The court recognized that although the doctor's actions at the time might have been well within the standards of the community, that was not sufficient to negate the allegation that a later-matured duty had been breached.<sup>9</sup> The appellate court reversed the lower court's grant of summary judgment for the doctor on the ground that a cause of action was made out by the continuing status of physician-patient where the danger arose out of that relationship.<sup>10</sup>

This Note will explore the newly recognized duty to warn a patient when the health care provider subsequently learns that previous non-negligent treatment is or may be harmful to him. The Note begins by discussing the need for a duty to follow up on medical treatment.<sup>11</sup> The proposed duty is analogized to existing forms of liability involving obliga-

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Cir. 1966); *Steeves v. United States*, 294 F. Supp. 446 (D.S.C. 1968); *Betenbaugh v. Princeton Hosp.*, 50 N.J. 390, 235 A.2d 889 (1967).

<sup>3</sup> *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Lopez v. Swyer*, 115 N.J. Super. 237, 279 A.2d 116 (1971), *modified*, 62 N.J. 267, 300 A.2d 563 (1973).

<sup>4</sup> RESTATEMENT (SECOND) OF TORTS § 328D (1965). *See St. John's Hosp. & School of Nursing, Inc. v. Chapman*, 434 P.2d 160 (Okla. 1967); *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944). *See generally* W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 40, at 230-31 (4th ed. 1971) (policy reasons justify the defendant carrying the burden of proof where defendant assumes some special responsibility toward the plaintiff).

<sup>5</sup> *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944) (the physician and his assistants would be called upon to meet the inference of negligence since they were in control of the unconscious plaintiff's body and the instrumentalities which may have caused the plaintiff's injuries).

<sup>6</sup> *Sindell v. Abbott Laboratories*, 26 Cal. 3d 558, 607 P.2d 924, 163 Cal. Rptr. 132, *cert. denied*, 449 U.S. 912 (1980) (many manufacturers of DES would be held liable for plaintiff's injuries although specific manufacturer of drug which was administered to the plaintiff's mother could not be identified).

<sup>7</sup> 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (1978).

<sup>8</sup> *Id.* at 669, 150 Cal. Rptr. at 392.

<sup>9</sup> *Id.*

<sup>10</sup> *Id.* at 672, 150 Cal. Rptr. at 394.

<sup>11</sup> *See infra* text accompanying notes 16-37.

tions to inform, to correct and to continue acting within a special relationship.<sup>12</sup> The Note then outlines the *prima facie* case for, and defenses to, an action for breach of the proposed duty to follow up.<sup>13</sup> It then considers objections that may be raised to the imposition of this duty, and offers answers to these objections.<sup>14</sup> Finally, this Note suggests several methods for limiting the doctor's vulnerability to this proposed form of action.<sup>15</sup>

## I. THE NEED FOR A DUTY TO FOLLOW UP

A duty to follow up on a patient's treatment after the physician is apprised of new data revealing danger in such mode of treatment is needed for several reasons. First, the physician is designated as the "learned intermediary" between medical products manufacturers and the patients who use the particular products. Second, this duty would be a mere expansion of the necessary obligation that is placed on physicians to disclose negligence when it occurs. Last, without a duty to follow up, many patients will incur unnecessary harm by being "kept in the dark" about new scientific discoveries.

### A. *The Physician As Learned Intermediary*

Many prescription drug users have unsuccessfully sued drug manufacturers on the proposition that the manufacturers had a duty to warn the patient of the drug's potential dangers.<sup>16</sup> The courts' reasoning in these cases has been based on the doctrine of the physician as the "learned intermediary."<sup>17</sup> In this capacity the doctor takes the information from the manufacturer, analyzes it and passes on the relevant warnings to his patients. There are two basic rationales for this doctrine: (1) the physician is in a better position to understand the dangers involved<sup>18</sup> and (2)

<sup>12</sup> See *infra* text accompanying notes 38-95.

<sup>13</sup> See *infra* text accompanying notes 96-123.

<sup>14</sup> See *infra* text accompanying notes 124-52.

<sup>15</sup> See *infra* text accompanying notes 153-57.

<sup>16</sup> See *infra* notes 17-21.

<sup>17</sup> *Brochu v. Ortho Pharmaceutical Corp.*, 642 F.2d 652 (1st Cir. 1981); *Stanback v. Parke, Davis and Co.*, 657 F.2d 642 (4th Cir. 1981); *Timm v. Upjohn Co.*, 624 F.2d 536 (5th Cir. 1980); *Reyes v. Wyeth Laboratories*, 498 F.2d 1264 (5th Cir. 1974); *Hoffman v. Sterling Drug, Inc.*, 485 F.2d 132 (3d Cir. 1973); *McCue v. Norwich Pharmacal Co.*, 453 F.2d 1033 (1st Cir. 1972); *Sterling Drug, Inc. v. Cornish*, 370 F.2d 82 (8th Cir. 1966); *Pierluisi v. E. R. Squibb & Sons, Inc.*, 440 F. Supp. 691 (D.P.R. 1977); *Dunkin v. Syntex Laboratories*, 443 F. Supp. 121 (W.D. Tenn. 1977); *Yarrow v. Sterling Drug, Inc.*, 263 F. Supp. 159 (D.S.D. 1967). See *Schenebeck v. Sterling Drug, Inc.*, 423 F.2d 919 (8th Cir. 1970). But see Comment, *Seley v. Searle*, 49 U. CIN. L. REV. 517 (1980) (discusses the first steps towards the eradication of the learned intermediary rule).

<sup>18</sup> *Gravis v. Parke, Davis and Co.*, 502 S.W.2d 863, 870 (Tex. 1973) (holding that plaintiff could recover against drug manufacturer only upon a showing that

the physician's knowledge and skill allow him to take into account the propensities of the drug by weighing the benefits and the dangers, thereby enabling him to make an informed choice.<sup>19</sup>

Therefore, manufacturers of prescription drugs have been released from liability due to the generally accepted rule that the manufacturers have a duty to warn the medical profession of potential dangers, not the public.<sup>20</sup> However, the court in *Seley v. G.D. Searle & Co.*<sup>21</sup> emphasized that "the purpose of imposing a duty to warn is to protect the patient against unwarranted or unexpected injury. The duty to warn is for the ultimate benefit of the patient."<sup>22</sup> Upon this proposition many courts presume that the doctor will relay the warnings to the patient.<sup>23</sup> Clearly, when the doctor initially prescribes the treatment, he has a duty to pass on manufacturers' warnings due to the necessity of obtaining informed consent.<sup>24</sup> However, the desirable expansion of physician responsibility would demand that physicians relay warnings received subsequent to the initial treatment decision. In the *Tresemmer* case, the imposition of this duty required the defendant-doctor to notify his patient of the dangerous attributes of her I.U.D. when this information became known in the medical community.

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the drug was defective, not merely because the patient was unaware of the possible side effects).

<sup>19</sup> *Reyes v. Wyeth Laboratories*, 498 F.2d 1264, 1276 (5th Cir. 1974) (pharmaceutical companies have a duty to warn prescribing physician of dangers inherent in prescription drugs).

<sup>20</sup> See *supra* note 19. But cf. Dixon, *Drug Product Liability: Information for Safety*, 16 TRIAL 62 (1980). The official source for communicating drug information is the package insert. It defines the indications for drug use, the contraindications, the warnings, the adverse reactions, the dosage and the administration information. The insert goes to the druggist; however, some patient package inserts have been developed, e.g., for oral contraceptives and asthma products. *Id.* at 66; *Lukaszewicz v. Ortho Pharmaceutical Corp.*, 510 F. Supp. 961 (E.D. Wis. 1981) (the Fed. Food, Drug and Cosmetic Act requires manufacturers of birth control pills to give warnings directly to the patient); 21 C.F.R. § 310.501 (1978). See also *Bryant v. Technical Research Co.*, 654 F.2d 1337 (9th Cir. 1981) (manufacturer is not necessarily relieved from its duty to warn later purchasers merely because it warned immediate buyer).

<sup>21</sup> 15 Ohio Op. 3d 338 (1980) (*per curiam*) (it is the duty of a drug manufacturer to warn the prescribing physician of any possible dangers connected with the prescription drug, not the patient or the general public).

<sup>22</sup> *Id.* at 346.

<sup>23</sup> "If the doctor is properly warned . . . there is an excellent chance that injury to the patient can be avoided." *Sterling Drug, Inc. v. Cornish*, 370 F.2d 82, 85 (8th Cir. 1967); "[T]he duty to warn the patient, if one exists, lies with the physician and not with the drug manufacturer." *Dunkin v. Syntex Laboratories*, 443 F. Supp. 121, 123 (W.D. Tenn. 1977); "If the doctor has been properly warned of the possible side effects, then we believe it is his duty to convey this warning on to the patient. . . ." *Gravis v. Parke, Davis and Co.*, 502 S.W.2d 863, 870 (Tex. 1973). See *Hoffman v. Sterling Drug, Inc.*, 485 F.2d 132, 142 (3rd Cir. 1973).

<sup>24</sup> See *infra* text accompanying notes 43-48.

Since it is obvious that the patient benefits only upon receipt of the warning, the duty to follow up is a logical link in the "learned intermediary" chain specifically fashioned for patient protection.

### B. *Expanding The Duty to Disclose Medical Negligence*

The official establishment of an affirmative duty requiring physicians to reveal instances of malpractice which they participate in or witness has been proposed.<sup>25</sup> The various reasons given for this proposal include: (1) the inadequacies of the medical profession's policing system;<sup>26</sup> (2) the unequal nature of the doctor-patient relationship;<sup>27</sup> (3) the threat of additional physical harm;<sup>28</sup> (4) the decrease in the likelihood of a successful malpractice suit;<sup>29</sup> and (5) the fact that many malpractice victims would go uncompensated because, through no fault of their own, they were unaware of the negligence.<sup>30</sup>

The duty to follow up patients' treatment is a necessary extension of the duty to disclose negligence. The duties are identical in several ways: the patient is unaware of the harmful aspect of the treatment,<sup>31</sup> the doctor is aware of the danger<sup>32</sup> and the patient's health is being risked.<sup>33</sup> The major difference is that the duty to disclose malpractice encompasses immediate negligent behavior on the part of the doctor,<sup>34</sup> while the duty to follow up involves alerting patients to treatment that—although not negligent when initiated—has become unacceptable to the medical profession. Of course, the physician would not be liable for malpractice as long as the treatment fell within the then-accepted professional standard of medical practice.<sup>35</sup> However, allowing a patient to be kept ignorant of

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<sup>25</sup> Vogel, *To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes*, 28 U.C.L.A. L. REV. 52 (1980). See also Hagman, *The Medical Patient's Rights to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 71 U.C.L.A. L. REV. 758, 803 (1970) (analysis of various situations in which a patient has a right to know the truth about his health status). Cf. *Baldor v. Rogers*, 81 So. 2d 658 (Fla. 1955) (a physician has a duty to inform patient that the prescribed treatment has failed and that the patient's only prospect of recovery is found in other treatments; the court does not assume that the initial treatment is negligent; therefore, the doctor must disclose the failure of unsuccessful non-negligent treatment, which appears to be an even greater duty than the disclosure of medical negligence).

<sup>26</sup> Vogel, *supra* note 25, at 58-61.

<sup>27</sup> *Id.* at 61-62.

<sup>28</sup> *Id.* at 62-63.

<sup>29</sup> *Id.* at 63-64.

<sup>30</sup> *Id.* at 58.

<sup>31</sup> *Id.* at 58.

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> It has been traditional with the medical profession that the acceptable stan-

potential health hazards remarkably resembles the failure to disclose negligence. In both situations the patient is injured (or has the possibility of being injured) while the physician has knowledge regarding the patient's health status and, in essence, forces the patient to incur unnecessary physical harm.

Undeniably, the ultimate goal in obtaining the guidance of a medical professional is to benefit one's health. The effect of both the duty to disclose malpractice and the duty to follow up medical treatment will better promote the purpose for which one seeks professional help.

### C. *The Patient Has Less Access to Medical Information*

The reasons for seeking professional medical advice most frequently evolve from the belief that health care providers are able to draw on their superior medical knowledge in order to diagnose and treat ailments. It is generally understood that medical professionals undergo rigorous training and years of education in preparation for their careers.<sup>36</sup> No one doubts the complexities of human anatomy and physiology, and those who choose to study medicine are admired for their achievements. It is precisely this admiration and the realization of the physician's abundant wisdom which draws the layman to the doctor's office. It is pure foolishness to suggest that the non-professional has even a small percentage of the medical know-how possessed by the average doctor. Besides the schooling aspect, the layman lacks access to medical data which the physician has at his disposal. Therefore, even if we assume that the patient is somehow able to diagnose his ailment, he will be virtually unable to identify the proper, most current mode of treatment. Doctors, on the other hand, receive updated literature regarding the drugs they prescribe, attend medical seminars regarding new treatments, take "refresher" medical courses, consult with an endless variety of specialists and read current medical and scientific journals.

While the layman finds himself relegated to using medical information that has filtered down the media funnel (often misinterpreted and editorialized), the physician has the ability to understand complicated

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dard of care be defined in terms of the skill possessed by the practitioner in good standing for the community in which he practices. However, this distinction—commonly known as the "locality rule"—has virtually disappeared due to the rise in standardized medical education throughout the country. Evidence is now required to show that the physician's conduct was in accord with recognized medical practice. Expert testimony is used for these evidentiary requirements. *But see* *Helling v. Carey*, 84 Wash. 2d 514, 519 P.2d 981 (1974) (the generally recognized medical standard of care may not insulate the defendant from liability).

<sup>36</sup> In addition to completing a bachelor's degree education, the medical student attends medical school for four years and then serves a period as an intern. The education process continues with a period as a resident at a hospital. If the doctor chooses to specialize in a certain area of medicine he will receive even more training.

medical vocabulary, thereby enabling him to examine the available professional literature and draw his own conclusions.<sup>37</sup> When seeking medical attention the patient is actually paying to use the educated mind of his physician. The doctor's brain is constantly being "re-programmed" with additional, and contemporary data, and it is this on-going effort which makes the physician's skill so very marketable. Since it cannot be denied that the health care provider has a much wider access to medical literature, the duty to follow up will assure that the patient gets equal access to all pertinent information which may affect his well-being.

## II. ANALOGOUS FORMS OF LIABILITY

The duty to follow up on a patient's treatment after knowledge is obtained regarding the propensities of the initiated therapy rests on two assumptions: (1) there are occasions when a duty to inform, correct or amend exists; and (2) these duties arise out of a special relationship between the plaintiff-patient and defendant-doctor—a relationship embodying a continuous obligation of care. The receipt of information allows for autonomy in decision-making thus permitting an individual to establish a high degree of self-determination. Since "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body,"<sup>38</sup> it naturally follows that each person also has a right to obtain the information necessary to make that determination. The duty to correct or amend is an outgrowth of the duty to inform. It is obvious that obsolete information is virtually useless, and in many cases, out-dated information will actually harm those who rely on it. The duty to correct is based on the belief that when *A* can foresee the possibility that *B* will be harmed due to information given by *A* now known to be false or misleading, *A* is in a position to prevent unnecessary injury to *B*.<sup>39</sup> The RESTATEMENT (SECOND) OF TORTS describes the duty to correct in the following manner:

### Duty to Act When Prior Conduct is Found to be Negligent

- (1) If the actor does an act, and subsequently realizes or should realize that it has created an unreasonable risk of causing

<sup>37</sup> As a rule, consumers generally lack the technical expertise and training needed to fully appreciate developments in the safety of consumer goods even if they were able to gather current safety information. Cf. 1 L. FRUMER & M. FRIEDMAN, *PRODUCTS LIABILITY* § 8.01, at 143, 152-54 (1981).

<sup>38</sup> *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), *overruled on other grounds*, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

<sup>39</sup> See *Cruthirds v. R.C.I., Inc.*, 624 F.2d 632 (5th Cir. 1980) (owner-occupier owes his guests the duty to correct hazards on his property if he knows or should know of the hazard). See also *Bernard v. Village of Andover*, 8 A.D.2d 993, 997, 188 N.Y.S.2d 879, 883 (1959) (Halpern, J., dissenting) (imposing duty on police officers to obtain medical attention for an individual in need, especially where officers either took the individual into custody or actively interfered with him).



physical harm to another, he is under a duty to exercise reasonable care to prevent the risk from taking effect.

- (2) . . . Subsection (1) applies even though at the time of the act the actor has no reason to believe that it will involve such a risk.<sup>40</sup>

This tort compensation theory supports the notion that when a doctor realizes that harm is foreseeable to one of his patients and knows that he could prevent or minimize the injury by relaying information to the patient he is obligated to help preclude the injury.<sup>41</sup> The unwary person, who is literally at the mercy of another due to his reliance upon that person's knowledge, must be protected.<sup>42</sup>

#### A. *Existing Duties to Inform or Correct*

It is generally recognized that a doctor has the duty to inform his patient of the risks which may be involved in proposed medical treatment.<sup>43</sup> The

<sup>40</sup> RESTATEMENT (SECOND) OF TORTS § 321 (1965). Comment a states that the rule applies whether the original act was tortious or *innocent*. *Id.* (emphasis added). See also *Scindia v. De Los Santos*, 451 U.S. 156 (1981) (there are circumstances in which the shipowner has a duty to act where a danger arises not of his own negligence but of which he becomes aware).

<sup>41</sup> See *Yarrow v. Sterling Drug, Inc.*, 263 F. Supp. 159 (D.S.D. 1967) (drug manufacturer has a duty to warn medical profession when he knows that some persons would be injured by a drug's side effects); *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (therapist owes duty to disclose dangerous propensities of patient to his declared victim); *Kelly v. Carroll*, 219 P.2d 79 (Wash. 1950) (if a drugless healer knows that his treatment will be of no help to the patient he must tell the patient and if he knows of a treatment which will work, he must inform the patient of that fact); *Tredt v. Haugen*, 294 N.W. 183 (N.D. 1940) (if a doctor discovers that he cannot cure a person by what he is doing or if he finds out that what he is doing will not be helpful he has a duty to tell his patient); *Cf. Benson v. Dean*, 232 N.Y. 52, 152 N.E. 323 (1930) (a doctor may be found guilty of malpractice when he has a patient who does not improve and he fails to advise the patient to resort to others with wider experience).

<sup>42</sup> See *Rowland v. Christian*, 69 Cal. 2d 108, 117, 443 P.2d 561, 564, 70 Cal. Rptr. 97, 100 (1968) (the following factors must be considered when deciding whether a duty to warn exists: (1) foreseeability or harm; (2) closeness of the connection between the defendant's conduct and the plaintiff's injuries; (3) the moral blame attached to defendant's conduct; (4) the policy of preventing future harm; and (5) the availability of insurance).

<sup>43</sup> *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 2d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914), *overruled on other grounds*, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905). However, it is generally recognized that the doctor will not have to obtain the patient's consent in an emergency situation or where the doctor feels that the patient would be emotionally traumatized if he were to be apprised of the possible risks involved in the proposed treatment. For a discussion of the present informed consent re-

rationale for the imposition of this duty directly flows from the above-noted interest in individual decision-making.<sup>44</sup> In order to decide among the various treatment alternatives proposed by the physician, the patient must have ample data from which to draw conclusions and formulate a knowing and intelligent determination.

The patient is entitled to rely upon the physician to tell him what he needs to know about the condition of his own body. The patient has the right to chart his own destiny, and the doctor must supply the patient with the material facts the patient will need in order to intelligently chart that destiny with dignity.<sup>45</sup>

The duty to inform is "measured by patient's need, and that need is whatever information is material to the decision."<sup>46</sup> The doctrine of informed consent may be used by analogy to impose a duty to follow up. Assuming, *arguendo*, that the doctor-patient relationship continues after initial treatment,<sup>47</sup> it is impossible to say that the patient has consented to a mode of treatment later found to be negligent unless he is informed of the subsequent findings. It is clear that once the patient is "in the dark" regarding the dangers of his medical therapy his original consent agreement does not encompass the "post-physician notification" treatment. Under the doctrine of informed consent the physician will be liable for any injury resulting from treatment rendered without the patient's knowledge of material risks which, if known, would have compelled the patient to select an alternative treatment.<sup>48</sup> Therefore, by analogy, a doctor should be liable for any injury resulting from treatment or therapy continued after the doctor has received updated medical information of which the patient is not apprised, because the patient no longer has the full range of material risk information to which he is entitled. It goes without saying that the vast majority of patients would not continue a mode of therapy found to be dangerous to their health. The disclosure will result in the patient's selection of another alternative, which may even amount to a complete discontinuance of medical treatment.

As a result of tort law developments in the products liability field, the

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quirements and how the discretion of the doctor undercuts the purpose of the informed consent requirement, see Glass, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533 (1970).

<sup>44</sup> Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

<sup>45</sup> Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975) (a plaintiff who alleges that a physician failed to warn him of material risks inherent in his treatment need not produce expert medical testimony that the doctor should have told the patient about the risk).

<sup>46</sup> Cobbs v. Grant, 8 Cal. 3d 229, 246, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).

<sup>47</sup> See *infra* text accompanying notes 96-103 for a discussion of the duration of the doctor-patient relationship.

<sup>48</sup> Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975).

manufacturers of most products have various obligations to warn product purchasers.<sup>49</sup> Certain warnings must be given at the time of sale although there is no "defect" in the construction or design of the product itself.<sup>50</sup> Other warnings—post-sale warnings—are often required after the purchase of the product.<sup>51</sup> It is a reasonable analogy that information given at the time of sale can be compared to the concept of informed consent, and post-sale warnings are analogous to the proposed duty to follow up the treatment of former patients. This Note will now discuss the duty of issuing point-of-sale warnings and how these warnings are a necessary supplement to a consumer's sphere of information.

Even though a product is not manufactured negligently, some dangers may exist even in its proper use. If the manufacturer knows of these possible dangers he is under a duty to inform the prospective buyer at the time of sale.<sup>52</sup> The rationale behind this duty is extremely similar to the rationale underlying the doctor's duty to obtain informed consent. Warnings at the time of sale help the purchaser evaluate the product and aid him in making an appropriate choice—a selection having the least dangerous attributes. The process of obtaining a patient's informed consent to treatment allows the patient to assess the various treatment alternatives and permits him to make a selection having the fewest risks.<sup>53</sup> Respect for autonomy in decision-making as well as concern for the safety of patients and consumers is reflected in both products liability and medical negligence areas.

The existence of a duty to inform naturally includes the requirement that the information be truthful and complete. When information given is false or incomplete an action for misrepresentation may be pursued by the injured plaintiff. Misrepresentation will serve as the basis for a cause of action in tort as long as the deceitful words or actions are relied upon by the plaintiff causing him harm.<sup>54</sup> In some instances, the tort of misrepresentation takes the form of nondisclosure—a passive, silent fraud as opposed to an active, deceitful statement or action.<sup>55</sup> As a general rule the nondisclosure, in order to be actionable, must (1) be a half-truth;<sup>56</sup> or (2) be between a plaintiff and defendant who are in a fiduciary relation-

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<sup>49</sup> See 1 L. FRUMER & M. FRIEDMAN, *supra* note 37, § 8, at 143-188 (1981).

<sup>50</sup> See *infra* text accompanying notes 52-53.

<sup>51</sup> See *infra* text accompanying notes 74-85.

<sup>52</sup> W. PROSSER, *supra* note 4, § 96, at 646-47, § 99, at 659. Of course, a manufacturer is under no duty to warn a prospective buyer of obvious inherent dangers, e.g., the sharp edge of a knife.

<sup>53</sup> See *supra* text accompanying notes 43-48.

<sup>54</sup> See RESTATEMENT (SECOND) OF TORTS § 311 (1965). Negligent misrepresentation "finds particular application where it is a part of the actor's business or profession to give information upon which the safety of the recipient . . . depends." *Id.* at comment b. See also W. PROSSER, *supra* note 4, §§ 105-110, at 683-736.

<sup>55</sup> W. PROSSER, *supra* note 4, § 106, at 695.

<sup>56</sup> *Id.* at 696.

ship.<sup>57</sup> Some courts have allowed the plaintiff to maintain an action when the defendant has special knowledge or means of acquiring information not readily available to the plaintiff.<sup>58</sup> Concealment of malpractice may also constitute a cause of action in fraud.<sup>59</sup> Nondisclosures in other fields likewise constitute actions for misrepresentation.<sup>60</sup>

Failure to relay information received subsequent to treatment which would bear on the patient's well-being closely resembles the nondisclosure type of misrepresentation. Of course, this kind of misrepresentation would be the silent, passive form of the tort. Although this is more difficult to prove than misrepresentation involving deceitful words and actions, it can be done. First, the plaintiff-patient could analogize the failure to follow up to a type of half-truth. One sort of half-truth situation is where one person has made a statement and then acquires new information that makes the statement false.<sup>61</sup> He is under a duty to "disclose such information to anyone whom he knows to be still acting on the basis of the original statement . . . ."<sup>62</sup> A doctor who treats a patient and then becomes aware of new data rendering the previously prescribed treatment unacceptable should be bound to alert this patient since it must be assumed that the patient still believes that the treatment had only the risks originally described.<sup>63</sup>

Second, since courts recognize a nondisclosure action when the plaintiff and defendant are in a fiduciary relationship,<sup>64</sup> the plaintiff-patient can demonstrate that he and the physician were fiduciaries.<sup>65</sup>

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<sup>57</sup> *Id.* at 697.

<sup>58</sup> *Id.*

<sup>59</sup> *Simcusi v. Saeli*, 44 N.Y.2d 442, 377 N.E.2d 713, 406 N.Y.S.2d 259 (1978). When a physician commits malpractice and then conceals the fact, the patient will have a cause of action for the fraud as well as malpractice if the patient can prove that: 1) the physician knew the fact of the malpractice; 2) the doctor made material factual misrepresentations to the patient with respect to the subject matter of the malpractice; 3) all elements of the tort of fraud can be proved; and 4) the conditions caused by the malpractice could have been corrected or alleviated. *Id.* *Lopez v. Swyer*, 115 N.J. Super. 237, 251, 279 A.2d 116, 124 (1971), *modified*, 62 N.J. 267, 300 A.2d 563 (1973). *But see* *Millet v. Dumais*, 365 A.2d 1038 (Me. 1976) (a physician will be liable for failing to disclose specific acts which, if known, might give rise to an action for medical negligence); *see* *Vogel*, *supra* note 25, at 67-69.

<sup>60</sup> *See* *Neel v. Magana*, 6 Cal. 3d 176, 491 P.2d 421, 98 Cal. Rptr. 837 (1971) (attorney failed to disclose malpractice); *Hobart v. Hobart Estate Co.*, 26 Cal. 2d 412, 159 P.2d 958 (1945) (stockbroker concealed wrongdoings).

<sup>61</sup> *W. PROSSER*, *supra* note 4, § 106, at 696.

<sup>62</sup> *Id.*

<sup>63</sup> *See supra* notes 36-37 and accompanying text for a discussion of patient's lack of access to medical information.

<sup>64</sup> *See supra* note 54.

<sup>65</sup> *Berkey v. Anderson*, 1 Cal. App. 790, 804, 82 Cal. Rptr. 67, 77 (1969) (holding that since the doctor and patient are fiduciaries, the doctor breaches his duty to disclose if he understates the seriousness of the patient's proposed treatment).

[T]he relationship between a doctor and his patient is of such a confidential and vital nature that an affirmative duty requiring the doctor to disclose to his patient fully the facts of the medical case does exist and . . . silence in this regard may be sufficient to infer a constructive misrepresentation.<sup>66</sup>

Fiduciary relationships require a "full and fair disclosure to the beneficiary of all facts which materially affect his rights and interests."<sup>67</sup> New findings which would affect a person's physical health fall within this category. Therefore, when a doctor fails to reveal these newly-acquired material facts to his fiduciary—his patient—he is guilty of a misrepresentation. Instituting the proposed duty will allow plaintiff-patients to fashion a cause of action that would permit recovery for a form of nondisclosure. The proposition is a natural expansion of the long-standing tort of misrepresentation.

### B. *Existing Duties of Continuing Care*

Once the doctor-patient relationship is established<sup>68</sup> the doctor is negligent if he abandons his patient.<sup>69</sup> The rationale for punishing physicians who abandon their patients is founded upon the belief that patients depend and rely upon their doctors.<sup>70</sup> The failure of a doctor to up-date his patients as he acquires new information is tantamount to abandonment.<sup>71</sup> When a patient is abandoned he no longer benefits from the medical expertise and skill of his doctor; when a physician fails to deliver new information to his patient, the patient likewise no longer profits from the medical attention to which he has become accustomed. Furthermore,

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See also *supra* note 59. But cf. *Millet v. Dumais*, 365 A.2d 1038 (Me. 1976) (doctor has no obligation to give patient "legal advice" by disclosing malpractice).

<sup>66</sup> *Lopez v. Swyer*, 115 N.J. Super. 237, 251, 279 A.2d 116, 124 (1971), modified, 62 N.J. 267, 300 A.2d 563 (1973) (a physician has an affirmative duty to disclose fully the facts of the patient's case; failure to do so may infer a constructive misrepresentation).

<sup>67</sup> *Neel v. Magana*, 6 Cal. 3d 176, 189, 491 P.2d 421, 429, 98 Cal. Rptr. 837, 845 (1971).

<sup>68</sup> See *infra* text accompanying notes 96-103.

<sup>69</sup> *Ascher v. Gutierrez*, 533 F.2d 1235 (D.C. Cir. 1976); *Murray v. United States*, 329 F.2d 270 (4th Cir. 1964); *Bolles v. Kinton*, 83 Colo. 147, 263 P. 26 (1928); *Shapira v. United Medical Serv., Inc.*, 15 N.Y.2d 200, 205 N.E.2d 293 (1965). For a discussion of the duration of the doctor-patient relationship, see *infra* text accompanying notes 96-103.

<sup>70</sup> If patients did not rely on their doctor's continuous care and attention they would have no reason to complain if their doctor suddenly and without warning had deserted them. Since the courts find abandonment to be objectionable, it naturally follows that patients have a right to rely upon their physician's continued vigilance.

<sup>71</sup> "Continued personal attention may be deemed unnecessary, but the physician must then advise the patient upon his future care and treatment." *Murray v. United States*, 329 F.2d 270, 272 (4th Cir. 1964).

a physician is negligent if he allows intervals to elapse between his visits when the patient needs attention.<sup>72</sup> This problem has surfaced all too frequently in the area of adverse drug reactions. When the physician does not schedule a return visit by the patient, he is unable to determine whether the patient is experiencing a harmful drug response.<sup>73</sup> Whether a doctor prescribes a drug that may have side effects or receives vital information regarding new discoveries relating to treatment methods that he has utilized, it is obvious that his patient needs immediate attention. Therefore, just as a physician is held liable for abandonment, he should likewise be answerable when he allows an interval of time to elapse while his patient remains uninformed about newly discovered dangers in his previous treatment. Liability for breaching the duty to follow up has roots in the abandonment theory.

Liability for a form of "abandonment" also exists in the products liability field. Many courts have held that manufacturers are under a continuing duty to notify the purchasers of their products when latent defects are discovered after sale.<sup>74</sup> It has been noted that:

the ultimate consequence of this continuing duty once a defect has been discovered avoids the defense that, *when sold*, the product was not unreasonably dangerous. Plaintiff is able to reply that regardless of the care exercised during manufacture or the state of the art at the time of sale, his claim rests on the manufac-

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<sup>72</sup> *Stacy v. Williams*, 253 Ky. 353, 69 S.W.2d 697 (1934); *Neudeck v. Vestal*, 117 Cal. App. 266, 3 P.2d 595 (1931).

<sup>73</sup> See *Dixon, Drug Product Liability: Information for Safety*, 16 TRIAL 62, 66 (1980); *Tozer, Medical-Legal Aspects of Adverse Drug Reactions*, 1970 L. MED. ANN. 245, 257.

<sup>74</sup> See *Schenebeck v. Sterling Drug, Inc.*, 423 F.2d 919, 922 (8th Cir. 1970), *cert. denied*, 400 U.S. 829 (1970) (possible effects and latent dangers of drugs); *Braniff Airways, Inc. v. Curtiss-Wright Corp.*, 411 F.2d 451, 453 (2d Cir. 1969), *cert. denied*, 396 U.S. 959 (1969) (aircraft); *Noel v. United Aircraft Corp.*, 342 F.2d 232 (3d Cir. 1965) (aircraft); *doCanto v. Ametek, Inc.*, 367 Mass. 776, 782, n.9, 328 N.E.2d 873, 879, n.9 (1975); *Comstock v. General Motors Corp.*, 358 Mich. 163, 176, 99 N.W.2d 627, 634 (1959) (products hazardous to life). See generally *Patterson, Products Liability: The Manufacturer's Continuing Duty to Improve His Product or Warn of Defects After Sale*, 62 ILL. B.J. 92 (1973) (historical overview demonstrating courts' growing strictness in the application of the continuing duty to warn consumers); *Comment, Products Liability: Post-Sale Warnings*, 1978 ARIZ. ST. L.J. 49 (the factors to look at regarding post-sale warnings are: (1) the magnitude of the potential consequences; (2) the difficulties of providing the warning; and (3) the seller's degree of negligence in the creation of the dangerous condition. In determining whether the post-sale duty to warn will be excessive, the following elements must be weighed: (1) the number of products sold; (2) the records normally kept by a seller of its purchases; (3) the continuing relationship between seller and user; and (4) the length of time since the sale).

Statutory requirements calling for the notification of consumers regarding latent defects in certain goods are found in 15 U.S.C. § 1418 (1976 & Supp. V 1981) and 46 U.S.C. § 1451 (1976).

turer's failure to take additional steps to protect or warn the public of the defect.<sup>75</sup>

In fact, many of these warnings are accompanied by court-mandated<sup>76</sup> or statute-mandated<sup>77</sup> recalls. Some courts have even gone as far as imposing a continuing duty on manufacturers to improve their products by upgrading safety devices.<sup>78</sup> Once a safety improvement has been developed it has been proposed that the manufacturer is under an obligation to notify product users of the subsequent safety advancement.<sup>79</sup> However, this new duty may be limited to those products not mass-produced.<sup>80</sup>

The duties of issuing post-sale warnings and notifying consumers of subsequent safety improvements mirror the proposed physician's duty to follow up on his patients' treatment. Both of these products liability obligations deal with items which at the time of sale were not known to require extra point-of-sale warnings and were thought to be made as safely as possible. It is at a later date that the manufacturer becomes aware either that latent defects have been discovered or that superior safety features have been developed. This parallels a physician's treat-

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<sup>75</sup> Patterson, *supra* note 74, at 92.

<sup>76</sup> See *United States v. K-N Enterprises, Inc.*, 461 F. Supp. 988 (N.D. Ill. 1978) (where drug was misbranded or unapproved and where it was likely that harm would result by the continued distribution of the drug, an injunction would issue requiring the recall of the drug); see generally Fleming, *The Duty of Manufacturer to Recall Aircraft*, 45 J. AIR L. & COM. 518 (1980) (stressing the important interest that the aviation community has in assuring that aviation manufacturers promptly advise users of defects in their products discovered after sale).

<sup>77</sup> See 15 U.S.C. § 1411 (Supp. V 1975); 15 U.S.C. § 2064 (1972). Note, *Mandatory Food and Drug Recalls—An Analysis of a Developing FDA Enforcement Tool*, 1980 UTAH L. REV. 809; Werber, *Automobile Recall Campaigns: Proposals for Legislative and Judicial Responses*, 56 U. DET. J. URB. L. 1083 (1979) (discusses National Traffic and Motor Vehicle Safety Act of 1966 and proposed amendments; proposes viable products liability defenses based on owner's failure to comply with the recall).

<sup>78</sup> *Noel v. United Aircraft Corp.*, 342 F.2d 232, 237 (3d Cir. 1964); cf. *Complaint of Bankers Trust Co.*, 651 F.2d 160 (3d Cir. 1981) (shipowner has a duty to use reasonable means to acquire knowledge calculated to inform him of conditions likely to produce or contribute to unseaworthiness. "He must create reasonable procedures for identifying the need for repairs and relaying reports of ship conditions to shoreside management." *Id.* at 171).

<sup>79</sup> *Kozlowski v. John E. Smith's Sons Co.*, 87 Wis. 2d 882, 275 N.W.2d 915 (1979) (technological advancement in sausage stuffer); see Note, *The Manufacturer's Duty to Notify of Subsequent Safety Improvements*, 33 STAN. L. REV. 1087 (1981). But see *Jackson v. New Jersey Mfrs. Ins. Co.*, 166 N.J. Super. 448, 400 A.2d 81 (1979) (no duty to alert customers of safety improvements in operation of rubber mills).

<sup>80</sup> *Kozlowski v. John E. Smith's Sons Co.*, 87 Wis. 2d at 901, 275 N.W.2d at 923-24. The court expressed concern over the excessive costs of notifying large numbers of consumers.

ment which was chosen after relevant information regarding risks was revealed to the patient<sup>81</sup> and at the time was administered as safely as possible.<sup>82</sup> Some time after treatment the doctor is apprised either that the treatment once thought to be acceptable no longer meets the requisite standard of care or that a safer method for treatment administration has been approved and is in use. The limit placed on a manufacturer's post-sale warning duty regarding mass-produced goods probably would not affect the proposed physician's duty since most doctors do not aid vast numbers of patients with the same treatment.<sup>83</sup>

The reason for imposing post-sale warning duties on manufacturers is to provide consumers with current information regarding safety improvements which is not readily available to purchasers.<sup>84</sup> This purpose correlates with the above-discussed fact that patients have less access to medical literature than do their physicians.<sup>85</sup> The concern for safety requires the imposition of post-sale duties; the interest in health maintenance necessitates a mandatory post-treatment obligation for physicians.

Other professionals also may have an analogous duty of continuing care. For example, an attorney may be made aware of changes in the law that would affect his client's interests, thus triggering a duty to contact his client in order to make necessary changes.<sup>86</sup> In addition, if a conflict of interest is brought to an attorney's attention, he is under a duty to correct the situation.<sup>87</sup> Moreover, a prosecutor is under a duty to correct the testimony of a witness if he knows it to be false.<sup>88</sup> The importance of correcting misleading or incomplete information is demonstrated by

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<sup>81</sup> See *supra* notes 43-48 and accompanying text for a discussion of informed consent.

<sup>82</sup> If the physician failed to meet the recognized standard of care *at the time of treatment* it is obvious that the patient has a cause of action for medical negligence.

<sup>83</sup> Therefore, the cost concerns that the court recognized in *Kozlowski v. John E. Smith's Sons Co.*, 87 Wis. 2d at 901, 275 N.W.2d at 923-24, would not be relevant.

<sup>84</sup> Note, *supra* note 79, at 1090-93. But see Epstein, *Products Liability: The Search for the Middle Ground*, 56 N.C.L. REV. 643 (1978). The trend in products liability case law is towards stricter standards for warnings and instructions. The rationale for this is based on the *false* assumption that "the individual product user . . . does not have and cannot obtain or act upon information from sources other than the manufacturer." *Id.* at 653.

<sup>85</sup> See *supra* notes 36-37 and accompanying text.

<sup>86</sup> *Sutherland v. Sutherland*, 192 Va. 764, 767, 66 S.E.2d 537, 542 (1951) (changes in probate law are systematically referred to clients whose wills are in the attorney's care).

<sup>87</sup> *In re Benjamin R. Patterson*, \_\_\_ U.S. \_\_\_, 101 S.Ct. 2301 (1981) (Burger, C.J., dissenting).

<sup>88</sup> *Napue v. Illinois*, 360 U.S. 264 (1959) (the failure of a prosecutor to correct the testimony of a witness which he knew to be false denied the petitioner due process of law in violation of the 14th Amendment).



Rule 26 of the FEDERAL RULES OF CIVIL PROCEDURE which outlines the requirements for supplementing discovery responses.<sup>89</sup>

Accountants, likewise, are under a continuing duty to correct errors in financial statements that are discovered at a later date.<sup>90</sup> The administrator of an estate must correct errors in the decedent's tax return when he becomes aware of them.<sup>91</sup> A corporation's management must correct errors or false rumors that can be attributed to the corporation when the mistaken information surfaces in the market-place<sup>92</sup> or appears in the press.<sup>93</sup> Employers<sup>94</sup> have a duty to notify their bonding companies and bailees<sup>95</sup> have an obligation to notify their bailors upon discovery of new information that relates to the agreement or contract between them.

The foregoing review of existing tort duties demonstrates that a court will find great support for a duty to follow up previous treatment plans. Each of the duties discussed is compatible with the proposed liability expansion. When the concern for health information is combined with the fiduciary duties arising from the doctor-patient relationship, the outcome strongly suggests the necessity for courts to impose a continuing duty upon physicians to inform their patients of new, significant medical findings.

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<sup>89</sup> FED. R. CIV. P. 26(e) requires supplementation of discovery responses: (1) when the party becomes aware of the identity and location of persons with knowledge of discoverable material; (2) when the party decides to call an expert witness at trial; (3) when the party realizes that the original discovery response was incorrect when made; (4) when the party knows that the original response is no longer true; (5) when ordered by the court or agreement of the parties. The situation in (4) is directly analogous to the situation where a physician finds out that his original treatment is no longer acceptable.

<sup>90</sup> *Redington v. Touche Ross & Co.*, 612 F.2d 68, 73 n.7 (2d Cir. 1979) (while it may be true that accountants have a continuing duty to correct any errors in prior financial statements, such continuing duty cannot operate to make every one of a firm's subsequent audits the same "transaction or occurrence" referred to by FED. R. CIV. P. 13(a)).

<sup>91</sup> *Glaze v. United States*, 641 F.2d 339, 342 (5th Cir. 1981) (decedent's administrator has a duty to correct the decedent's tax return to reflect the decedent's proper marital status).

<sup>92</sup> See *State Teachers Retirement Bd. v. Fluor Corp.*, 654 F.2d 843, 850 (2d Cir. 1980) (a company might involve itself so much in the preparation of reports and projections by outsiders as to assume a duty to correct material errors in those projections).

<sup>93</sup> See *Electronic Specialty Co. v. International Controls Corp.*, 409 F.2d 937, 949 (1969) (while a corporation may choose to correct a misstatement in the press not attributable to it, the Securities Exchange Act of 1934 does not require a corporation to do so).

<sup>94</sup> *USLIFE Sav. & Loan Assoc. v. National Surety Corp.*, 115 Cal. App. 2d 336, 345, 171 Cal. Rptr. 393, 398 (1981) (citing *Tresemmer v. Barke*, 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (1978)).

<sup>95</sup> *Allan v. Bekins Archival Serv. Inc.*, 91 Cal. App. 2d 835, 154 Cal. Rptr. 458 (1979) (citing *Tresemmer v. Barke*, 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (1978)).

## III. ELEMENTS OF THE DUTY TO FOLLOW UP

A. *The Prima Facie Case*

When the courts adopt the proposed cause of action for breaching the duty to follow up, the plaintiff will have to prove the following elements in order to establish a prima facie case: (1) that a doctor-patient relationship existed between the plaintiff and defendant; (2) that during the existence of that relationship the doctor received notice of a newly discovered danger in the mode of treatment, rendering that treatment below the requisite degree of care; (3) that the doctor did not notify or attempt to notify the patient regarding this new discovery; and (4) that as a result of the failure to notify, the patient suffered injury.

The existence of a doctor-patient relationship is established when a physician begins to see a patient on a professional basis. The physician-patient relationship "springs from a consensual transaction, a contract, express or implied, general or special."<sup>96</sup> It is not difficult to show that a doctor-patient relationship has been initiated; however, it may be difficult to prove that the doctor-patient relationship was actually in force at the time when the doctor received notice regarding newly discovered dangers in his method of treatment.<sup>97</sup> It is generally recognized that the doctor-patient relationship lasts until: (1) it is ended by mutual consent;<sup>98</sup> or (2) the physician withdraws after giving reasonable notice to the patient;<sup>99</sup> or (3) the physician is dismissed by the patient;<sup>100</sup> or (4) the physician's services are no longer needed;<sup>101</sup> or (5) an equally qualified doctor replaces the withdrawing physician.<sup>102</sup> If the doctor dismisses the patient for any other reason and the patient is thereby injured, the doctor may

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<sup>96</sup> *Lyons v. Grether*, 218 Va. 630, 632, 239 S.E.2d 103, 105 (1977). See also *Ahnert v. Wildman*, 376 N.E.2d 1182 (Ind. Ct. App. 1978) (the law of contract governs the rights and liabilities of the doctor-patient relationship and the doctor-patient relationship does not extend to filling out the patient's medical insurance forms).

<sup>97</sup> *Hagman*, *supra* note 25, at 771. This article states that in some respects a physician-patient relationship is a continuing relationship; "Continued personal attention may be deemed unnecessary, but the physician must then advise the patient upon his future care and treatment." Cf. *Murray v. United States*, 329 F.2d 270, 272 (4th Cir. 1964).

<sup>98</sup> *Lyons v. Grether*, 218 Va. 630 at 633, 239 S.E.2d at 106; *Sibert v. Boger*, 260 S.W.2d 569, 572 (Mo. 1953). Both cases discuss the various methods for terminating the doctor-patient relationship. It does appear that most methods require initiation by either the doctor or his patient. Relying on a "passive termination" could result in legal consequences for the doctor.

<sup>99</sup> *Lyons v. Grether*, 218 Va. at 633, 239 S.E.2d at 106; *Sibert v. Boger*, 260 S.W.2d 569, 572 (Mo. 1953).

<sup>100</sup> *Sibert v. Boger*, 260 S.W.2d at 572.

<sup>101</sup> *Ascher v. Gutierrez*, 533 F.2d 1235, 1236 (D.C. Cir. 1976); *Lyons v. Grether*, 218 Va. at 633, 239 S.E.2d at 106; *Sibert v. Boger*, 260 S.W.2d at 572.

<sup>102</sup> *Ascher v. Gutierrez*, 533 F.2d at 1236.

be sued for abandonment.<sup>103</sup> In a suit based upon the proposed duty to follow up, the focus will be on the fourth method of terminating the doctor-patient relationship stated above and the burden of proof will be on the plaintiff-patient to demonstrate that the services of the doctor were still needed. The *Tresemmer* court allowed the plaintiff-patient to state a cause of action even though she apparently had not maintained a continuous visitation relationship with her gynecologist.<sup>104</sup> Therefore, a court must assume that the services of the doctor are still necessary when he receives notification of any dangers in his patient's treatment.

The plaintiff will be able to show the existence of a doctor-patient relationship if (1) he did not consent to a termination; (2) he did not receive notice of the doctor's withdrawal; (3) he did not dismiss the physician from his case; and (4) his case was not taken over by another doctor.

After the plaintiff has established the existence of a doctor-patient relationship, he must show that during this relationship the physician received notice of a newly discovered danger in the mode of treatment. There are various ways in which a doctor can obtain the newest information about current medical trends. First, he may receive a "Dear Doctor" letter from a drug manufacturer or other health appliance provider. These letters often signal new scientific findings and warnings to which the doctor must pay attention and use with his current practice procedures. Second, a drug or appliance salesman or detailman may visit the physician and pass on the new information during his visit. Again the doctor must treat this information seriously since the salesman presumably has superior intimate knowledge of his product. Third, the physician may acquire knowledge via continuing studying and reading of the latest medical journals. Last, the doctor may discover new warnings while studying a recent edition of the *Physician's Desk Reference*, an annual reference book designed to inform doctors of the various attributes of prescription and non-prescription drugs. If the patient can show that his doctor received a warning via any method including the four listed above, he has met the burden of proof required for establishing the second element in the *prima facie* case.

The plaintiff must also show that the doctor did not notify him of the new findings. This will be a simple question of fact for the jury.

Finally, in order to state a cause of action for breaching the duty to follow up, the patient will have to prove that he sustained an injury as a result of the physician's breach. In most cases the harm actually will be the additional injury to the patient as a result of the breach, *i.e.*, the amount of compensation will be limited to only those injuries sustained after the warning was received and after a reasonable time elapsed in order to notify the patient. Injury as a result of the initial treatment will not satisfy this element *unless* it can be shown that the initial injury was

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<sup>103</sup> For a discussion of abandonment, see *supra* text accompanying notes 68-73.

<sup>104</sup> *Tresemmer v. Barke*, 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (1978).

compounded by the lack of notification or unless the patient can prove that, had he known earlier, corrective measures that would have halted the onset of further harm could have been instituted.

### B. *Defenses*

If the above-stated elements are established the plaintiff will prevail unless the defendant-doctor can rely successfully on one of the following defenses: (1) the patient was contributorily negligent; (2) the warning to the doctor was eroded by the manufacturer's overpromotion of the drug or device; (3) due diligence did not result in the location of the patient; or (4) the physician used his discretion in deciding not to notify the patient of the new findings.

The contributory negligence of the patient will be examined by the court in determining whether a possible defense exists for the doctor.<sup>105</sup>

<sup>105</sup> In a pure comparative negligence jurisdiction the contributorily negligent plaintiff's recovery is reduced in proportion to the amount of negligence attributed to the plaintiff. As of 1981 six jurisdictions have statutes mandating a pure comparative negligence system: Louisiana, LA. CIV. CODE ANN. art. 2323 (West 1979); Mississippi, MISS. CODE ANN. § 11-7-15 (1972); New York, N.Y. CIV. PRAC. LAW §§ 1411-13 (McKinney 1975); Puerto Rico, P.R. LAWS ANN. tit. 31, § 5141 (1956); Rhode Island, R.I. GEN. LAWS §§ 9-20-4 to 4.1 (1972); Washington, WASH. REV. CODE ANN. § 4.22.010 (1973).

Another five states have judicially adopted pure comparative negligence: Alaska, Kaatz v. State, 540 P.2d 1037 (Alaska 1975); California, Nga Li v. Yellow Cab Co., 13 Cal. 3d 804, 532 P.2d 1226, 119 Cal. Rptr. 858 (1975); Florida, Hoffman v. Jones, 280 So. 2d 431 (Fla. 1973); Michigan, Placek v. City of Sterling Heights, 405 Mich. 638, 275 N.W.2d 511 (1979); New Mexico, Scott v. Rizzo, 96 N.M. 682, 634 P.2d 1234 (1981).

The most popular comparative negligence system is a "fifty percent" system. The following have adopted a form of this system where contributory negligence will bar a plaintiff if it is either equal to or greater than the negligence of the defendant: Arkansas, ARK. STAT. ANN. §§ 27-1763 to 27-1765 (1975); Colorado, COLO. REV. STAT. § 1331-111 (1975); Georgia, GA. CODE ANN. §§ 94-703, 105-603 (1855); Idaho, IDAHO CODE §§ 6-801 to 6-806 (1971); Kansas, KAN. STAT. ANN. § 60-258(a)-(b) (1976); Maine, ME. REV. STAT. ANN. tit. 14, § 156 (1971); North Dakota, N.D. CENT. CODE § 9-10-07 (1973); Utah, UTAH CODE ANN. §§ 78-27-37 to 78-27-43 (1973); Wyoming, WYO. STAT. § 1-1-109 (1977). West Virginia judicially adopted this fifty percent comparative negligence system. Bradley v. Appalachian Power Co., 256 S.E.2d 879 (W. Va. 1979).

In the following jurisdictions the plaintiff's negligence will bar his claim only if it is greater than that of the defendant: Connecticut, CONN. GEN. STAT. ANN. § 52-572(h), (i), (l) (West 1977); Hawaii, HAWAII REV. STAT. § 663-31 (1976); Massachusetts, MASS. GEN. LAWS ANN. ch. 231, § 85 (West 1973); Minnesota, MINN. STAT. ANN. §§ 604.01-.02 (West 1978); Montana, MONT. CODE ANN. §§ 27-1-702 to 27-1-703 (1977); Nevada, NEV. REV. STAT. § 41.141 (1979); New Hampshire, N.H. REV. STAT. ANN. § 507:7-a (1970); New Jersey, N.J. STAT. ANN. §§ 2A:15-5.1 to 2A:15-5.3 (1973); Ohio, OHIO REV. CODE ANN. § 2315.19 (Page 1980); Oklahoma, OKLA. STAT. ANN. tit. 23, § 13 (West 1979); Oregon, OR. REV. STAT. §§ 18.470-.510 (1975); Pennsylvania, PA. STAT. ANN. tit. 42, § 7102 (Purdon 1978); Texas, TEX. CIV. CODE ANN. Art. 2212a, §§ 1-2 (1973); Vermont, VT. STAT. ANN.

Since negligent acts on the part of the plaintiff will have a serious effect on the amount of his recovery, the various forms of patient negligence will be examined closely. First, a patient is under a duty to cooperate with his doctor.<sup>106</sup> If the doctor can show either that the patient did not follow instructions<sup>107</sup> or failed to return to the physician when advised<sup>108</sup> the court might be able to conclude that the patient had terminated his relationship with the doctor, thus negating the first element in the *prima facie* case.<sup>109</sup> However, if the court believes that the patient's failure to cooperate did not extinguish the doctor-patient relationship, it is most likely that the defense attorney would be unable to prove that the doctor's failure to notify the patient was due to the lack of the patient's cooperation. It would not be enough for the defense attorney to show merely that the plaintiff's negligence made his injury worse; rather, the plaintiff's contribution *must* be tied to the doctor's failure to follow up. It seems that this defense rarely would be successful. Even in cases where the patient did not return to the doctor when advised, the doctor would still be able to furnish follow-up information by phone or letter.

Second, a patient could fail to inform the doctor of his address or phone number.<sup>110</sup> That type of negligent behavior on the part of the patient is directly related to the failure of the physician to follow up on the patient's treatment since the doctor would be unable to relay warnings to the patient. This dimension of the contributory defense would seem to be the most successful; however, it is unlikely that the patient would refuse to give the doctor his address and telephone number.

Third, in those jurisdictions which still recognize implied assumption

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tit. 12, § 1036 (1979); Virgin Islands, V.I. CODE ANN. tit. 5, § 1451 (1973); Wisconsin, WIS. STAT. ANN. § 895.045 (West 1971).

Two states allow the plaintiff to recover fully as long as his negligence is slight and the defendant's negligence is gross: Nebraska, NEB. REV. STAT. § 25-1151 (1978); South Dakota, S.D. CODIFIED LAWS ANN. § 20-9-2 (1964).

The remaining twelve states bar the plaintiff from recovery where he is found to have been negligent in any degree. For a thorough discussion of comparative negligence systems, see V. SCHWARTZ, *COMPARATIVE NEGLIGENCE* (1974 & Supp. 1981).

<sup>106</sup> *Skar v. City of Lincoln*, 599 F.2d 253, 260 (8th Cir. 1979); *Brazil v. United States*, 484 F. Supp. 986, 991 (N.D. Ala. 1979); *Meacham v. McLeay*, 193 Neb. 457, 227 N.W.2d 829 (1975).

<sup>107</sup> *Watkins v. United States*, 589 F.2d 214, 225 (5th Cir. 1979) (Skelton, J., dissenting).

<sup>108</sup> *Gerber v. Day*, 119 Cal. App. 446, 6 P.2d 535 (1931) (a doctor is not liable for medical negligence where patient failed to return to physician for further treatment as advised).

<sup>109</sup> For a discussion of the termination of the doctor-patient relationship see *supra* text accompanying notes 96-103.

<sup>110</sup> *Cf. Ray v. Wagner*, 286 Minn. 354, 357, 176 N.W.2d 101, 104 (1970) (discussing the physician's duty to notify his patient regarding the patient's test results).

of the risk as a complete bar to recovery<sup>111</sup> or as a form of contributory negligence,<sup>112</sup> only those risks that are unreasonable should be allowed to stand as a defense.<sup>113</sup> For example, it would be an unreasonable assumption of the risk if the patient failed to take any steps after the doctor notified him that his previous treatment was no longer acceptable. Therefore, the patient should not be allowed complete recovery for his injuries. However, it would not be unreasonable if the patient failed to take any action after merely reading about the danger of his past treatment in a magazine or newspaper. The patient must not be expected to take on the doctor's responsibilities; he may wait until he is notified by his physician before seeking an alternative treatment.

The second defense, erosion of the warning due to the overpromotion of the drug, has been successful in several areas of malpractice litigation.<sup>114</sup> The court in *Stevens v. Parke, Davis and Co.*<sup>115</sup> held that "an adequate warning to the medical profession may be eroded or even nullified by overpromotion of the drug through a vigorous sales program which may have the effect of persuading the prescribing doctor to disregard the warnings given."<sup>116</sup> If the defense attorney can show that the drug or device was overpromoted, the court may hold that the plaintiff failed to state a cause of action for breach of duty to follow up because the second element of the action (doctor's receipt of the warning) was nullified. However, the patient should be free to take legal action against the manufacturer since the manufacturer's actions resulted in a failure to comply with the products liability requirements.<sup>117</sup>

The third defense, failure to locate the patient, would require the doc-

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<sup>111</sup> Although the following states have adopted a form of comparative negligence, implied assumption of the risk is still a total bar to recovery: Arkansas, Georgia, Mississippi, Nebraska, Rhode Island and South Dakota. V. SCHWARTZ, *supra* note 105, at § 9.3. In a jurisdiction where contribution is an absolute defense courts do not have to distinguish between contributory negligence and assumption of the risk.

<sup>112</sup> Those states allowing contributory negligence to be used in reducing plaintiff's damages most likely will also allow an unreasonable implied assumption of the risk to be used in reducing plaintiff's damages. V. SCHWARTZ, *supra* note 105, at § 9.4.

<sup>113</sup> For policy reasons an implied assumption of a reasonable risk will in all probability not be used to reduce the plaintiff's recovery when he acts in a reasonable manner, even though he encounters a risk. *Id.* at § 9.1.

<sup>114</sup> *Stevens v. Parke, Davis and Co.*, 9 Cal. 3d 51, 507 P.2d 653, 107 Cal. Rptr. 45 (1973), *relying on* *Love v. Wolf*, 226 Cal. App. 2d 378, 38 Cal. Rptr. 183 (1964) (manufacturer may not be able to rely on learned intermediary theory to escape liability for drug dangers if the drugs have been overpromoted to the physician).

<sup>115</sup> *Id.*

<sup>116</sup> *Id.* at 65, 507 P.2d at 661, 107 Cal. Rptr. at 53.

<sup>117</sup> *Schenebeck v. Sterling Drug, Inc.*, 423 F.2d 919 (8th Cir. 1970), *cert. denied*, 400 U.S. 829 (1970).

tor to show that he made a good faith effort, using due diligence, to locate the patient. Many factors must be evaluated in order to determine whether the doctor's efforts to locate the patient meet the requisite standard of care. It is imperative that the doctor issue personal notices as opposed to ads in a newspaper, for example. Although media notices are accepted for many legal purposes, where an individual's health is concerned the doctor must not rely upon the mere chance that his patients would read the general warning. The preferred method—from the standpoint of expense and probability of success—would be for the physician to mail a letter to the patient's last known address explaining the new warning. The envelope should bear the doctor's return address along with notations instructing the post office to forward if possible and return the letter if unable to forward. To prevent the patient from discarding the letter without reading its contents, the envelope should indicate that the message inside is very important. The letter should instruct the patient to notify the doctor upon receipt of the message so that the physician knows that his efforts have been successful. If within a reasonable time (ten to fourteen days, for instance) the doctor has not been contacted by the patient he should attempt to phone the patient or issue another letter. If the physician still does not succeed in contacting the patient he should send a telegram or a registered letter if the hazard warrants this special attention.<sup>118</sup> At this point the doctor has met the requisite standard of care and may invoke his efforts as a defense.

The last defense is based upon the physician's use of discretion in choosing not to warn the patient. The doctor is given room for discretion in obtaining informed consent. Therefore, in an emergency situation<sup>119</sup> or when it appears that the patient would be emotionally traumatized by the information,<sup>120</sup> the doctor is excused from revealing the material risks to his patient. This discretion may carry over to the duty to follow up. As far as what information must be relayed to the patient, it seems logical to use the same standard used in informed consent cases, that is, the material risk standard.<sup>121</sup> Therefore, if the reasonable person would take the information into consideration when making a decision to pursue a treatment alternative, the information is deemed material and the doctor is under a duty to pass it along to his patient. As a guideline for the physician, it is reasonable to conclude that any treatment method found to be below the standard of care is definitely material information about

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<sup>118</sup> Due to the cost of these measures the physician could use his discretion in determining whether another method might be equally satisfactory in the situation. Of course, if the foreseeability of serious danger is extreme (for example, the possibility that a patient who is a pilot could lose consciousness due to a defective prescription) the physician is expected to incur these expenses.

<sup>119</sup> See *supra* note 43.

<sup>120</sup> *Id.*

<sup>121</sup> *Miller v. Kennedy*, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd*, 85 Wash.2d 151, 530 P.2d 334 (1975).

which the patient must be informed.<sup>122</sup> When it appears rather certain to the doctor that the patient would suffer a detrimental effect in response to the new warning, the physician may use his discretion in deciding whether to inform the patient. It would have to be shown that the effect on the patient would be worse than the danger in allowing the patient to remain uninformed about the new findings.<sup>123</sup>

#### IV. POSSIBLE OBJECTIONS TO THE DUTY TO FOLLOW UP

There exists a group of possible objections to the imposition of a duty for the physician to relay follow-up information to his patients. Those opposed to this proposed duty could suggest: (1) that the record-keeping necessitated by this duty would invade the patient's privacy expectations; (2) that this duty has the effect of imposing a strict liability standard on the medical profession; (3) that carrying out the duty to follow up would be extremely expensive; (4) that the doctor would be forced to admit malpractice; and (5) that the doctor's practice would be damaged by his admission that his previous treatment method was dangerous.

##### A. *Record-Keeping and the Concern for Privacy*

Other areas in the tort field require extensive record-keeping.<sup>124</sup> However, the proposed duty would necessitate a very detailed record procedure that could be extremely burdensome to the solo practitioner. It seems entirely possible that physicians would be forced to pool their patient records in a computer system.<sup>125</sup> Of course, this requires resolving the issue of the privacy of medical records. It is generally agreed that information about one's body is matter that the patient has a right to keep private.<sup>126</sup> Because of this belief, it is very difficult to obtain access

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<sup>122</sup> However, where a prescription drug is found to have possible immediate effects and the patient's prescription has already expired it would be useless for the doctor to issue a warning since the danger period would have passed.

<sup>123</sup> The doctor might be able to explain the warning to the patient's family thereby dispensing the facts without harming the patient's emotional well-being.

<sup>124</sup> 49 C.F.R. § 573 (1980) (specifies requirements for manufacturers to maintain lists of purchasers and owners of registered vehicles for the purpose of sending notices, bulletins and warnings); *See Whalen v. Roe*, 429 U.S. 589 (1976) (discusses New York statute designed to control traffic of dangerous drugs by requiring prescription information to be computer processed). *See also* Comment, *supra* note 74, at 57.

<sup>125</sup> *See generally* Miller, *Computers, Data Banks & Individual Privacy: An Overview*, 4 COLUM. HUM. RTS. L. REV. 1 (1972) (discussing the need to develop greater sensitivity to the dangers of information abuse since it is generally recognized that personal privacy is fundamental to individual autonomy).

<sup>126</sup> *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570 (3d Cir. 1980) (employee's medical records fall within the category of materials entitled to privacy protection; however, governmental interests might exist which could require records to be disclosed).



to medical files.<sup>127</sup> However, courts have allowed disclosure of medical records when there is a sufficient governmental interest. In *United States v. Westinghouse*,<sup>128</sup> the court stated that "[i]n the cases in which the court has allowed some intrusion into the zone of privacy surrounding medical records, it has usually done so only after finding that the societal interest in disclosure outweighs the privacy interest on the specific facts of the case."<sup>129</sup> In viewing privacy interests the courts have looked at the interest in developing treatment programs,<sup>130</sup> the need to control public health threats,<sup>131</sup> the degree and nature of the harm involved if the information was disclosed,<sup>132</sup> the degree of intrusion,<sup>133</sup> the possibility of obtaining necessary medical and psychological information<sup>134</sup> and the degree of embarrassment or stigma that might befall the patient.<sup>135</sup>

Society as a whole has much to gain from prompt attention given to medical problems.<sup>136</sup> When a person is exposed to possible harm and follow-up medical attention could prevent further injury, there is a substantial governmental interest that would outweigh the patient's personal privacy

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<sup>127</sup> *Id.* at 577; Freedom of Information Act, 5 U.S.C. § 552 (1976) (exemption six removes FOIA's mandatory disclosure requirement for personnel, medical and similar files); FED. R. CIV. P. 35 (Rule 35 requires a showing of "good cause" in order to subject a party to a physical or mental examination as a discovery process, as opposed to other discovery techniques which do not require a showing of "good cause.").

<sup>128</sup> 638 F.2d 570 (3d Cir. 1980) (the National Institute for Occupational Safety would be allowed to examine employee medical records if the employees were given adequate notice; the rationale given for this inspection was the strong public interest in facilitating medical research).

<sup>129</sup> *Id.* at 578.

<sup>130</sup> *Id.*

<sup>131</sup> *Id.*

<sup>132</sup> *Kurzon v. Dept. of Health & Human Serv.*, 649 F.2d 65, 69 (1st Cir. 1981) (disclosure of names of unsuccessful applicants for cancer research grants could not be withheld since the information was not sufficiently private and the degree of potential harm was so very minimal).

<sup>133</sup> *Id.*

<sup>134</sup> *H.L. v. Matheson*, 450 U.S. 398 (1981) (parents of minor child could be told about their child's request for an abortion).

<sup>135</sup> *Id.*; *cf. Brown v. FBI*, 658 F.2d 71, 75 (2d Cir. 1981) (disclosure of benefits received by kidnap victim). *But cf. Department of Air Force v. Rose*, 425 U.S. 352 (1976) (disclosure of case summaries of honors and ethics hearings was not allowed due to public interest concerning Air Force Academy's discipline administration).

<sup>136</sup> In a financial sense, prompt medical attention would be an effective means of lowering insurance settlements, disability payments and the like because many potential health problems could be caught before permanent disabling damage would occur. Also, for security reasons, a nation would want its citizenry to be as healthy as possible in order to defend itself in times of unrest. Lastly, many societies view the issue of prompt health care as a matter of pride—sick people cannot fight for their own cause so the nation, as a matter of self-esteem, takes responsibility for providing medical aid.

interests. Apparently, disclosure of these medical records to the proper agencies would allow warnings and notices to be passed along to patients who could take immediate steps to curtail further injury. Of course, indiscriminate disclosure of medical files would not be allowed. A security provision to insure the protection of the individual's privacy interest may be required to permit such an examination of medical records.<sup>137</sup>

The Supreme Court expressed concern for security provisions with regard to personal data in *Whalen v. Roe*.<sup>138</sup> "We are not unaware of the threat to privacy implicit in the accumulation of vast amounts of personal information in computerized data banks or other massive governmental files."<sup>139</sup> However, the Court went on to hold that if it can be shown that the data system has ample security provisions it will not be an invasion of the fourteenth amendment.<sup>140</sup> The concern for security will definitely increase in this situation. Computer data banks for this purpose will be required to employ some form of security administration.

### B. *Imposition of Strict Liability*

Physicians generally are held to the standard of care equal to that used by competent members of the profession.<sup>141</sup> The fact that a medical treatment has an unsuccessful outcome will not subject the physician to liability unless it can be shown that the doctor used a therapy method which is not accepted by the medical profession or that the doctor actually contracted to cure the patient.

Opponents of the proposed duty may argue that this duty will have the actual effect of imposing strict liability upon members of the medical community.<sup>142</sup> The rationale behind this misguided argument is the notion that no matter what safety precautions the doctor would take, he might still find himself liable for injuries resulting from previous treatment that was non-negligent. The fallacy of this argument is easily exposed. The proposal does *not* call for physician's liability for the initial

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<sup>137</sup> *General Motors Corp. v. National Inst. for Occupational Safety*, 636 F.2d 163, 166 (6th Cir. 1980) (employee medical records could be disclosed with proper security administration).

<sup>138</sup> 429 U.S. 589 (1976) (the court identified tax collection, supervision of public health, distribution of welfare and social security benefits, direction of the Armed Forces and enforcement of criminal laws as all requiring the use of computers to store vast quantities of information that would be potentially embarrassing or harmful to the individual were it to be indiscriminately disclosed).

<sup>139</sup> *Id.* at 605.

<sup>140</sup> *Id.* at 605-06.

<sup>141</sup> See W. PROSSER, *supra* note 4, § 32, at 162.

<sup>142</sup> The imposition of strict liability is usually found in the areas of products liability and unreasonably dangerous activities. Strict liability calls for liability regardless of the safety measures taken or the standard of care used. Defendants are held legally at fault, in spite of the fact that they are blameless. *Id.* §§ 75-81. See RESTATEMENT (SECOND) OF TORTS § 402A (1965).

treatment now found to be negligent. Rather, the duty only imposes an obligation to notify patients of new findings. This is *not* retroactive liability. A finding of negligence will be based upon the failure to follow up, not upon a finding that the doctor was negligent in failing to foresee that the initial treatment would someday be found to be below the requisite standard of care.

In order to protect himself from liability, the physician must merely treat his patients with the care expected of the medical profession and, in turn, notify his patients when he becomes aware of dangers in his past treatment method. The physician will not become strictly liable for future injuries resulting from therapy later found to be negligent, as long as he notifies his patients so that they may take measures to prevent further injury.

### C. *Expense of Patient Recall*

Opponents of the proposed follow up obligation might argue that the cost of this duty would be extremely burdensome to the physician. It is true that the "recall" campaigns—notification systems embodying the spirit of the proposed duty—of the recent past have been very expensive.<sup>143</sup> However, the cost of these recalls for mass-produced items has included television air time, newspaper space and bulk mailings. The individual physician would have the duty to notify a much smaller group; therefore, the need for media campaigns would simply not arise. Although the cost would vary widely, depending on the ease with which previous patients could be located and the number of patients to be notified, the cost involved would be well worth incurring. No doubt many of the warnings would actually result in a net income for the physician since a percentage of patients would probably return to the same doctor for corrective treatment or for an alternative therapy prescription.<sup>144</sup> These warnings to previous patients would not amount to advertising or solicitation even though doctors may realize some future "business" from them.

Physicians would not be required to "go to the ends of the earth" searching for their previous patients. An attempt to locate the patient is required and the physician will be able to satisfy that requirement by phone calls, letters and perhaps a telegram in a rare case. If all normal, relatively inexpensive modes of communication are exhausted and no patient is

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<sup>143</sup> For example, Firestone spent almost \$2 million in the recall notification for the Firestone 500 tire. *Tire Recall: Hearings of H.R. 1744 and 3949 Before the Subcomm. on Consumer Protection and Finance of the House Interstate and Foreign Commerce Comm.*, 96th Cong., 1st Sess. 12 (1979).

<sup>144</sup> Patients would not be entitled to "free" corrective treatment since the doctor's duty only encompasses the obligation to warn of subsequent safety measures, not the duty to warn and correct. The duty to warn and correct does exist in many of the recall campaigns for products, thereby making the recall a very expensive, money-losing venture.

located, the physician would be free to invoke his efforts as an affirmative defense.<sup>145</sup> Undoubtedly, the maintenance of good patient records with a method for updating this data would greatly aid in the task while reducing expenses at the same time.<sup>146</sup>

#### D. Doctor's Admission of Malpractice

Those opposed to the imposition of a duty to follow up might contend that by notifying past patients of dangers related to their treatment, a doctor is openly admitting that his previous therapy methods were actually malpractice. However, this is not the case. At the time of the initial treatment, the therapeutic method met the requisite standard of care. A successful cause of action for medical negligence must allege that at the *time* of treatment, operation, therapy, etc., the doctor's conduct fell below the recognized standard of care for the profession.<sup>147</sup> The doctor, by relaying information regarding the dangers in the initial treatment, is not stating that his previous actions were negligent.<sup>148</sup> The precise reason for using a standard of care guideline is to prevent defendants from being liable, regardless of their attempts to use currently accepted, safe treatment procedures.<sup>149</sup> Otherwise, all defendants would be subjected to strict liability,<sup>150</sup> a standard currently reserved for very few situations.<sup>151</sup> The imposition of the proposed duty does not force a doctor to guarantee his results<sup>152</sup> or to incur strict liability; however, it does obligate a doctor to assume responsibility for keeping his patients up-to-date on medical innovations affecting their prior treatment.

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<sup>145</sup> For a discussion of the defense based on failure to locate the patient see *supra* note 118 and accompanying text.

<sup>146</sup> For a discussion of the possible methods for a doctor to maintain patient information see *infra* note 153.

<sup>147</sup> *But see* *Helling v. Carey*, 84 Wash. 2d 514, 519 P.2d 981 (1974) (failure to test patient under 30 years of age for glaucoma found to be negligent even though doctor followed the recognized community standard. The court held that it was unreasonable not to have administered the simple and inexpensive test, where the outcome, if the test is not given, could be devastating.)

<sup>148</sup> Courts usually do not interpret the duty of physicians to disclose as requiring a doctor to admit his negligence. "[I]t does not necessarily follow that this obligation to disclose must include the peripheral possibilities of misjudgment and negligence," *Millet v. Dumais*, 365 A.2d 1038, 1041 (Me. 1976).

<sup>149</sup> If no amount of safety precaution would ensure a doctor from being liable for malpractice because of a poor result or newly discovered data, few, if any, individuals would choose to enter the medical profession.

<sup>150</sup> For a discussion of strict liability in the medical profession see *supra* notes 141-42 and accompanying text.

<sup>151</sup> Currently, strict liability is reserved for the areas of product liability, unreasonably dangerous activities, animal keepers, and certain types of criminal activity not requiring a *mens rea*. W. PROSSER, *supra* note 4, §§ 75-81.

<sup>152</sup> A physician may, although he seldom does, contract to cure his patient, or to accomplish a particular result, in which case he may be liable for

### E. *Damage to the Doctor's Practice*

The reputation of a physician's practice may be on the line when he finds it necessary to contact his previous patients regarding new findings that render his prior treatment method dangerous or negligent. Those opposed to this duty would conclude that the doctor's practice would be damaged. Quite to the contrary, however, many would view his attempt to warn as an indication of a conscientious mode of sincere care for his patients. Undoubtedly, many patients would be grateful for current information regarding the status of their health problems. Rather than reflecting a weakness in the physician's capabilities, the follow-up duty contemplates an admirable sense of responsibility. A doctor's practice could be damaged only if he was negligent in exercising his professional skills; no damage would occur if the doctor merely revealed his sense of responsibility for his patients by allowing them to decide whether they wanted to take steps to correct a possible health hazard.

### CONCLUSION

Progressive developments in tort theory have provided necessary help to aid plaintiffs in meeting the burden of proof required for compensation in medical negligence cases. The duty to follow up is a natural outgrowth of the continuing trend to provide patient-plaintiffs with indemnification for unnecessary suffering. In many ways the patient is at the mercy of his physician due to the dearth of understandable medical information available to the general public.

However, due to the vast amount of record-keeping<sup>153</sup> that would be required by this duty and the seemingly endless nature of this responsibility, the physician would do well to initiate some limitations to this duty. Since the doctor-patient relationship is based on contractual theory,<sup>154</sup>

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a breach of contract when he does not succeed. In the absence of such an express agreement, he does not warrant or insure the outcome of his treatment . . . .

*Id.* § 32, at 162.

<sup>153</sup> There are several methods that the doctor could utilize in order to create an effective method of record-keeping. Of course, on the individual patient charts the doctor should record all treatments, prescriptions and therapies used in connection with the individual. Next, this information could be "cross-referenced" in a manner similar to that recommended for use by doctors in preventing serious injuries from adverse drug reactions:

[H]e (the doctor) might consider keeping a diary in which to record the names of all patients who have received each drug, so that, when he receives a new warning from a detail man or a revised product card or a "Dear Doctor" letter, he can pass the warning on to every patient taking the drug . . . .

Tozer, *supra* note 73, at 257. As long as the physician's staff keeps accurate patient address records the physician should experience no difficulty in locating his former patients for the purpose of passing along treatment information.

<sup>154</sup> For a discussion of the contractual nature of the doctor-patient relationship

the doctor would be free to place restrictions on the contract provisions by relying on written agreements that could carry time limits<sup>155</sup> or disclaimers.<sup>156</sup> Of course, it would be necessary for the contracts to be well-constructed, easily understood and not of the adhesion variety.<sup>157</sup> If some form of limitation is not placed on this duty, the doctor virtually could be liable for updating patients whom he has not seen for many years.

With proper, fair-minded restrictions, the duty to warn a patient of subsequently learned dangers with regard to previous non-negligent treatment will surely demonstrate a sincere concern for health care as well as a concrete expression of the medical profession's ethical responsibilities.<sup>158</sup>

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see *supra* note 94 and accompanying text.

See Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FED'N RESEARCH J. 87. While discussing the concept of informed consent the author stated:

Given the legitimate concern with consent . . . physicians and patients (should) make explicit the rules governing their relationship, physicians should be urged to post in their offices the terms and conditions under which they will see patients; they should be encouraged to mail similar notices to patients before any treatment is provided. . . . There are elaborate agreements for common purchases of household goods; we need explicit agreements now for medical practice.

*Id.* at 128.

<sup>155</sup> For example, the written agreement to be signed by the patient could state: "This contract for follow-up professional medical services is in effect for 3 years from the date of your last appointment. If more than three years elapse from the date of your last appointment the doctor will not be responsible for relaying updated medical information regarding your treatment. It is your duty to notify the doctor of changes in your address or phone number." Cf. *Nash v. Meyer*, 54 Idaho 283, 31 P.2d 273 (1934) (if doctor contracts to give service only at his office he is not negligent if he fails to go to the patient's house to attend her after surgery).

<sup>156</sup> For example, the written agreement to be signed by the patient could contain the following disclaimer: "The doctor will assume absolutely no responsibility for updating you regarding your treatment. The doctor-patient relationship will exist on a visit-to-visit basis only. If you return to the doctor he will provide you with any new findings. If you choose not to return the doctor will not relay new data to you."

<sup>157</sup> An adhesion contract is a

[s]tandardized contract form offered to consumers of goods and services on essentially 'take it or leave it' basis without affording consumer realistic opportunity to bargain and under such conditions that consumer cannot obtain desired product or services except by acquiescing in form contract. Distinctive feature of adhesion contract is that weaker party has no realistic choice as to its terms.

BLACK'S LAW DICTIONARY 38 (5th ed. 1979).

<sup>158</sup> AMA PRINCIPLES OF MEDICAL ETHICS V (1980).

